

INSTRUCTIONS FOR THE W-9 "MEDICARE CLEARANCE FORM"

Please read the following instructions carefully. Correct use of the Medicare Clearance Form will help to expedite payments to your facility. Any questions regarding these instructions or the form itself can be referred to the Convalescent Payments Unit, at (860) 424-4951. If the client is being placed in a Medicare non-certified bed, you must use the W-9W Medicare non-certified bed placement form.

1. All client/provider information must be filled in completely:

- a. Client ID - Enter the EMS client ID number.
- b. Client Name - Enter the full name of the client.
- c. Provider ID - Enter the nine (9) digit provider ID.
- d. Provider Name - Enter the full provider name.

2. Admission/Transfer Date

- a. Enter the admission/transfer date the W-9 is being submitted for.
- b. Check whether this is the client's first admission, a readmission, or a transfer from a Medicare non-certified bed in the non-distinct part of the facility. (To be used by CCNH facilities that have approved distinct part status only. Not to be used when the client moves from a RHNS to CCNH level).

3. A. MEDICARE COVERED UPON ADMISSION - Check one of the listed boxes and indicate whether the client has traditional Medicare Part A or is enrolled in a Medicare HMO. Give name of Medicare HMO carrier.

1. Check this box if the client was covered by Medicare upon admission, but did not use their full available benefit days. A Medicare Determination Notice, RA, or HMO denial letter must be attached that verifies the first date of non-coverage. For purposes of appeal, please indicate whether the client died or was discharged within 30 days of the last date of coverage.
2. Check this box if the client was covered by Medicare for the full available benefit period. Be sure to include any days previously used in your facility or another nursing facility to total the full benefit period. A facility denial letter or Medicare Determination Notice/RA must be attached.
3. Check this box if the client was covered by Medicare through the date of discharge or death.
4. Check this box if the client was deemed in on Medicare subsequent to the admission date. A Medicare Determination Notice, RA, or HMO denial letter is required verifying the first day on non-coverage.

4. B. MEDICARE COVERAGE DENIED UPON ADMISSION - Check the appropriate box.

1. Check this box if the client met all of the technical requirements for Medicare coverage, but did not receive daily skilled nursing or rehabilitative services. A Medicare Determination Notice, RA, or HMO denial letter is required. If the client was discharged or died within 30 days of the admission date, indicate it in the place provided.
2. If the client did not meet one of the technical requirements for Medicare coverage, check the box indicating the reason for the denial as follows:
 - a. If the client did not have a qualifying hospital stay, and did not reside in the community within 30 days of the admission date, you may submit either a hospital W-10 if there was a hospital stay of less than three days, or if there was no hospital stay and the client was transferred from another facility or another level of care within your facility you may just indicate that in the comments section and no additional documentation is required. If the client resided in the community (including boarding homes or homes for the aged) within 30 days of the admission into your facility, you must attach a Medicare Determination Notice, RA, or HMO denial letter.
 - b. Check this box if the client's benefits were previously exhausted for this spell of illness. All benefit days previously used at your facility or another nursing facility must be listed in the fields provided. If the last day of Medicare coverage is greater than 60 days from the admission for which you are seeking payment, a Medicare Determination Notice, RA, or HMO denial letter is required. If the last day of coverage is less than 60 days, submit a copy of the facility denial notice.
 - c. Check this box if the client is under 65 and not entitled to Medicare Part A benefits.
 - d. Check this box if the client is over 65 and not entitled to Medicare Part A benefits.

5. C. OTHER THIRD PARTY LIABILITY COVERAGE EXISTS

If the client has other private health insurance or any other room and board payment source, including VA benefits, check this box and attach a completed W-9A.

MEDICARE CLEARANCE FORM

CLIENT ID:	PROVIDER ID:
CLIENT NAME:	PROVIDER NAME:

Admission/Transfer Date _____

Check one of the following: ☐ First Admission ☐ Readmission ☐ Transfer from Non-Distinct Part

Client Has: ☐ Traditional Medicare Part A ☐ Medicare HMO, give carrier name _____

☐ **A. MEDICARE COVERED UPON ADMISSION:** (check appropriate box below)

☐ 1. Medicare covered partially from _____ through _____ (Medicare Determination Notice, RA, or HMO denial letter required indicating 1st date of non-coverage.)

☐ 2. Medicare covered - benefits exhausted: _____ through _____
(Indicate previously used days here also)

_____ through _____ through _____
(Facility denial letter or Medicare Determination Notice/RA required.)

☐ 3. Medicare covered through discharge/transfer/date of death (circle one) of _____

☐ 4. Medicare deemed in on _____ through _____ (Medicare Determination Notice, RA, or HMO denial letter required.)

☐ **B. MEDICARE COVERAGE DENIED UPON ADMISSION:** (check appropriate box below)

☐ 1. Client met Medicare's technical requirements for coverage but did not receive daily skilled nursing care or rehabilitative services for the above admission/transfer date. (Medicare Determination Notice, RA, or HMO denial letter required.)

For purposes of appeal requests, please indicate if the client died or was discharged within 30 days of the above admission/transfer by giving date of discharge or death. _____

☐ 2. The client did not meet the technical requirements for Medicare coverage for the following reason:

☐ a. No qualifying hospital stay. (Attach appropriate documentation, see instructions)

☐ b. Benefits previously utilized or exhausted for this spell of illness. List **ALL** days previously used at your facility or any other nursing facility below: (Medicare Determination Notice, RA, or HMO denial letter required if last day of coverage is greater than 60 days, if less than 60 days, send facility denial notice.)

_____ through _____ through _____

_____ through _____ through _____

☐ c. Client under 65 no Medicare A benefits.

☐ d. Client over 65 no Medicare A benefits.

☐ **C. OTHER THIRD PARTY LIABILITY COVERAGE EXISTS** (W-9A required)

COMMENTS: _____

COMPLETED BY: _____

TELEPHONE # _____